Transparency

June 2015

Research Committee of the Colorado Commission on Affordable Health Care

What's the Problem?

- Markets don't work in the absence of adequate information on value; loss of price as accurate signal of value
- Health care for the most part has opaque pricing for individual services (exception: cash market)
- Interest growing in benefit design changes that reduce moral hazard: HDHPs, reference pricing

How Does Problem Contribute to Cost?

- Third party payer system blunts need for consumers to know prices/value at point of service, since their out of pocket often fixed (moral hazard)
- Perverse incentive to buy most expensive service, since someone else is paying most of bill
- False assumption: higher price = higher quality (because in other products, price signals quality)
- Lack of skepticism of ordering more/more expensive tests/procedures, while FFS biases consuming more units

EXHIBIT 1

Estimates of Waste in US Health Care Spending in 2011, by Category

	Cost to Medicare and Medicaid[a]			Total cost to US health care[b]		
	Low	**Midpoint**	**High**	**Low**	**Midpoint**	**High**
Failures of care delivery	$26	$36	$45	$102	$128	$154
Failures of care coordination	21	30	39	25	35	45
Overtreatment	67	77	87	158	192	226
Administrative complexity	16	36	56	107	248	389
Pricing failures	36	56	77	84	131	178
Subtotal (excluding fraud and abuse)	166	235	304	476	734	992
Percentage of total health care spending	6%	9%	11%	18%	27%	37%
Fraud and abuse	30	64	98	82	177	272
Total (including fraud and abuse)	197	300	402	558	910	1,263
Percentage of total health care spending				21%	34%	47%

SOURCE Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *JAMA* 307, no. 14 (April 11, 2012):1513–6.
NOTES Dollars in billions. Totals may not match the sum of components due to rounding. [a]Includes state portion of Medicaid. [b]Total US health care spending estimated at $2.687 trillion.

What Does the Research Say?

- Hibbard articles
  - Significant market shifts don't usually occur as the result of transparency on cost or quality alone
  - There is a beneficial effect, however, as providers in competitive markets often respond to reported relative low quality or high cost by correcting
  - Some evidence in elective services that cost can drive market shifts: reference pricing, bundles
- Shared decision-making increases patient satisfaction, mixed evidence on cost (stronger effects demonstrated in some studies, but studies of poorer quality)

Promising Practices from the Literature

- BHCAG experiment in MN
- Bundle pilot IHA/Anthem
- Cash market pricing
- Shared decision-making

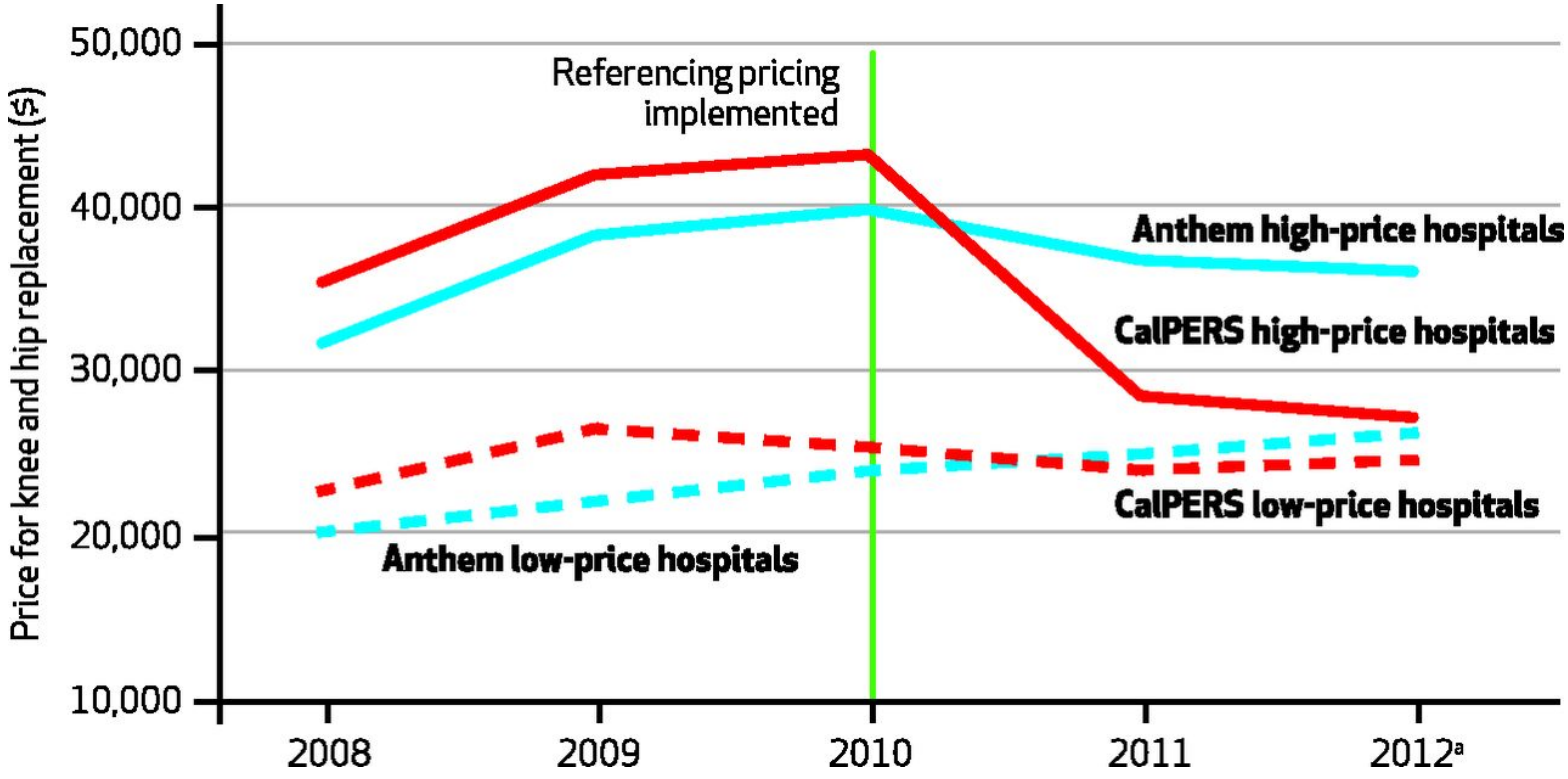
BCHAG experience: Minnesota

- Choice Plus program: health systems bid for complete coverage against one another; results placed into 3 tiers with differential cost-sharing for employees
- Payments to systems were risk-adjusted using ACG methodology
- Patient satisfaction and quality scores were reported (HEDIS)

BCHAG experience: Minnesota

- "After an adjustment is made for changing case-mix, the actual increase is only about 3 percent per year." (vs. nat'l 9% annual 1996-1998)
- ¾ of employees used cost/quality info in choosing care system
- 1% rise in employee premium = 1.6-4.3% drop in enrollment

Reference Pricing: CalPERS experiment



Robinson J C , and Brown T T Health Aff 2013;32:1392-1397

HealthAffairs

Cash pricing example: US vs UK

- Absent insurance induced moral hazard, pricing remarkably similar in different cash markets

	HCA UK in Pounds	HCA UK in Dollars ($1.54/£)	Surgery Center of Oklahoma
Open Inguinal Hernia	£2,883	$4,451	$3,060
Hip Replacement	£11,434	$17,655	$19,400
Hysterectomy	£8,667 and £8,217	$13,382 and $12,688	$8,000 (includes overnight)

What Are Other States Doing? Example: Ohio

Executive

- Adopt/promote nat'l standards for cost/ quality reporting
- Continued support of health information exchange
- Measure ROI on transparency
- Require transparency in licensing for insurers, facilities, and providers
- Vendor requirements for price and quality transparency in state contracts
- Provide price/quality data to prospective employers
- Join pub/pvt coalitions supporting transparency
- Monitor pricing trends to prevent collusion among insurers and/or providers

Legislative

- Require HPs and employers make price/ quality info available to enrollees
- Texas mandated release of claims data to employers/group policyholders on request
- Require pricing transparency from providers
- Funding for pub/pvt transparency partnerships

Source: Health Data Transparency Basics, Health Policy Institute of Ohio

What Information Gaps Exist?

- Price data incomplete
- Few quality standards, mostly primary care
- No single source of standard cost/quality metrics; Beta vs. VHS problem
- Uninsured/cash experience data missing from claims
- Purchasing information meaningful to individual consumer lacking
- Patient experience data lacking

Opportunities for Cost Savings in Colorado

Executive

- Adopt/promote nat'l standards for cost/ quality reporting *CIVHC*
- Continued support of health information exchange *CORHIO/QHN*
- Measure ROI on transparency *CIVHC/ CHI?*
- **Require transparency in licensing for insurers, facilities, and providers**
- **Vendor requirements for price and quality transparency in state contracts**
- Provide price/quality data to prospective employers *CIVHC*
- Join pub/pvt coalitions supporting transparency *CBGH*
- **Monitor pricing trends to prevent collusion among insurers and/or providers** *DOI*

Legislative

- Require HPs and employers make price/quality info available to enrollees
- **Mandated release of claims data to employers/group policyholders on request**
- Require pricing transparency from providers CRS 6-20-101,; 10-16-133, 134; 25-3-701-705
- **Funding for pub/pvt transparency partnerships**

How Do These Apply to the Filters?

- Absolute cost: 5% of spend, 15% of waste?
- Actionable: multiple actions possible as regulator, purchaser; see previous slide
- Public/private markets: applicable to both
- Future cost driver: will continue to be a factor in short/med term, hopefully diminishes as both public and private entities use big data to inform purchasers
- Can be evaluated: difficult to establish direct causality

What are the Opposing Viewpoints?

- Little evidence that consumers respond to cost/quality data to date (but providers do)
- Fear of gov't market intervention; interference with private negotiations may be detrimental to markets
- Transparency alone won't fix markets; if monopolies/oligopolies exist, transparent pricing may be ignored since there aren't alternatives

What are the Opposing Viewpoints?

- Provider concerns
  - Cost of data collection
  - Data at odds with provider self-perception of quality
  - Currency and accuracy of data pulls
  - Cherry-picking
  - Accuracy of risk adjustment